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CHRODIS+
IMPLEMENTING GOOD PRACTICES FOR CHRONIC DISEASES

GUIDE ON HOW TO APPLY CHRODIS + GOOD PRACTICES

based on results of Joint Action CHRODIS PLUS from 8 countries using

the Joint Action CHRODIS RECOMMENDATIONS AND CRITERIA (QCR)

Layman version

Authors: Core writing group on behalf of WP7 partners October 2020

This document arises from the Joint Action (JA) CHRODIS + addressing chronic diseases through cross-national initiatives identified in JA-CHRODIS to reduce the burden of chronic diseases while assuring health system sustainability and responsiveness, under the framework of the Health Programme (2014-2020). Sole responsibility lies with the author and the Consumers, Health, Agriculture and Food Executive Agency is not responsible for any use that may be made of in the information contained therein.

The **Guide for the implementation of JA CHRODIS Recommendations and Criteria** (in short: The Guide) provides a step-by-step tutorial for the acceptance and application of the JA CHRODIS Recommendations and Criteria (in short: **The QCR Tool**). The latter was originally developed in the Joint Action CHRODIS (2014-2017), an earlier initiative, which used Type 2 Diabetes (T2DM) as a model/example disease. Then, the QCR Tool was applied and tested in CHRODIS PLUS in a variety of settings through pilot actions (**tests** or **try-outs**) in Bulgaria, Croatia, Finland, Germany, Greece, Serbia, Slovenia and Spain. The test actions developed innovative practices in the fields of disease prevention, health promotion and healthcare, focusing on Type 1 and Type 2 Diabetes Mellitus, Tinnitus and other complex chronic conditions. **The experiences showed the potential for applicability of the QCR Tool to other conditions beyond Type 2 Diabetes Mellitus (T2DM)**.

This layman version of the Guide is aimed at the general public and readers who are not experts in the field of chronic disease management, but have an interest and desire to know more about the project and the work carried out in this specific part. It is expected that this version of the Guide will be used for spreading awareness as well.

Concise Dictionary & Keywords

Pilot Action: trial, testing ground, experimental try-out
Implementer: a representative who is applying a practice
Consensus Meeting: compromise and agreement meeting
Core Writing Group: project partners and experts in charge of writing the Guide
Target Population: beneficiary, intended users
SQUIRE 2.0: Standards for Quality Improvement Reporting Excellence

ESSENTIAL ELEMENTS OF THE GUIDE

JA CHRODIS Recommendations & Criteria (QCR) Tool	✓ List of the 9 JA CHRODIS Recommendations and Criteria (QCR tool) with visual representation of the framework/checklist in the form of a flower and narrative explanation.
How to adopt and apply a good practice in seven steps	✓ Establish the core leadership group and the implementation working group ✓ Scope of the practice ✓ Baseline analysis of situation and context ✓ Design of the pilot action plan ✓ Monitoring and evaluation of the implementation ✓ Reporting the results ✓ Planning for sustainability of the practice and to increase the potential for scale-up

Why was the Guide made?

The aim of the Guide is to help the **development**, **implementation**, **monitoring** and **evaluation** of practices in the fields of chronic disease management, health promotion and prevention interventions. The Guide outlines the recommended steps for a successful implementation process and provides insights into the practical experiences of those who used it throughout the Project. This Guide was developed in accordance with the actual implementation process and practical experiences of the pilot sites.

Objectives of the Guide and to whom is it aimed at?

The Guide is suited to be used as a **'top-down'** framework (or **checklist**) when the broad horizon of the implementation is considered by various interested parties. Nevertheless, as experienced by most partners in the project, **its use promotes the active and meaningful participation** of a wide variety of interested parties who are or will be in any way affected by the practice, and/or are involved in the practice's continuation and likelihood of its expansion. In terms of **usability**, while there are several improvements that can still be made to the Tool, there is an agreement among implementers and partners that the recommendations are a positive and useful checklist which support their implementation process. Even though the framework/checklist may still benefit from further testing, it shows the potential for applicability to settings outside T2DM.

How was the Guide made?

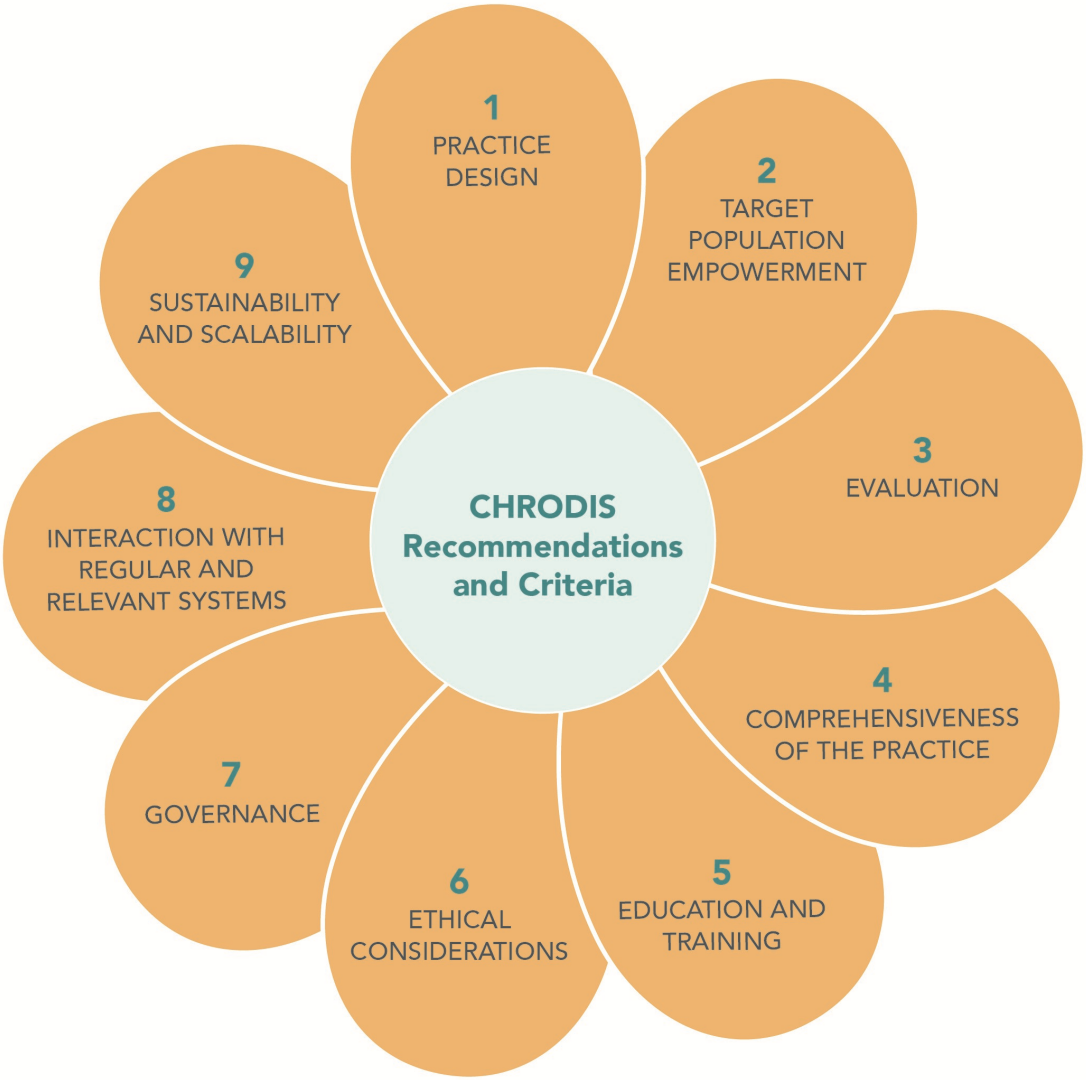
The Guide was developed by both the project partners and the pilot actions representatives (who worked onsite and brought up actual real-life experiences). The pilot actions took place in different health care systems, in different circumstances and were addressing different issues and challenges in a variety of areas. The project partners come from various educational backgrounds adding different viewpoints too. A **core writing group** was set up in the beginning of the process and it prepared the initial draft of the Guide. Finally, the Guide was then shared for modification and approval with all partners, pilot actions representatives and experts at a Consensus Meeting.

Summary of main recommendations in the Guide

- *Adoption of the QCR Tool to other contexts*: the experience with the pilot actions suggests that successful implementation of the framework requires **expert support**, **training** and **guidance to help** local implementers in interpretation and implementation. A more condensed and easier to understand version with translations into local languages may support the adoption of the framework/checklist more easily.
- *Future testing for improvements, applicability and transferability of the QCR Tool*: In order to further develop the framework and evaluate its applicability and transferability to other contexts, **additional testing and validation is needed**. Focus groups with the implementers and quality improvement experts would provide in-depth information on how to improve and validate the framework. *The patient perspective must be taken on board and integrated into these processes as well.*

- *Integration of knowledge and training on quality improvement to promote sustainability*: An attempt to integrate the knowledge obtained so far with that from other projects dealing with prevention and management of chronic diseases would be beneficial and perhaps set the stage for more effective future investment. The QCR Tool was originally developed to contribute to the cultural shift needed to redesign health care and social support systems in relation to diabetes. Its impact could be enhanced if accompanied by **targeted education modules** on the fundamentals of quality improvement.
- *Considering the digital era*: Increasing digitalisation of healthcare and other societal domains calls for the development of a **digital 'field' version** which as part of its design (as all apps e.g. are routinely) would have usability for healthcare professionals & citizen/patients at its heart.

Visual representation of the JA CHRODIS Recommendations and Criteria (QCR Tool)



Narrative explanation of the JA CHRODIS Recommendations and Criteria (QCR Tool)

1. Design of the Practice

The design should clearly specify aims, objectives, and methods, and rely upon relevant data, theory, context, evidence, and previous practices including pilot studies. The structure, organisation, and content of the practice is defined and established together with the clearly described target population (i.e., exclusion and inclusion criteria and the estimated number of participants). Human and material resources should be adequately estimated in relation to the committed tasks. Relevant dimensions of equity must be adequately taken into consideration and targeted.

2. Promote the Empowerment of the Target Population

The practice should actively promote the empowerment of the target population by using appropriate mechanisms, such as self-management support, shared decision-making, education-information, value clarification, active participation in the planning process, active participation in professional training, and considering interested parties' needs in terms of enhancing/acquiring the right skills, knowledge, and behaviour.

3. Define an Evaluation and Monitoring Plan

The evaluation outcomes should be linked to actions to foster continuous learning and/or improvement, and/or to reshape the practice. Evaluation and monitoring outcomes should be shared among relevant interested parties and linked to the stated goals and objectives, taking into account social and economic aspects from both the target population and formal and informal caregiver perspectives.

4. Comprehensiveness of the Practice

The practice should consider relevant evidence on effectiveness, cost-effectiveness, quality, safety, the main contextual indicators, and underlying risks of the target population using validated tools to individual risk assessment.

5. Include Education and Training

The practice should include educational elements to promote the empowerment of the target population (e.g., strengthen their health literacy, self-management, stress management, etc.). Relevant professionals and experts are trained to support target population empowerment, and trainers/educators are qualified in terms of knowledge, techniques, and approaches.

6. Ethical Considerations

The practice should be implemented equitably (i.e., proportional to needs). The objectives and strategy are transparent to the target population and interested parties involved. Potential

burdens (i.e., psychosocial, affordability, accessibility, etc.) should be addressed to achieve a balance between benefit and burden. The target population has the right to be informed, to decide about their care, and participation. Their right to confidentiality should be respected and enhanced.

7. Governance Approach

The practice should include organizational elements, identifying the necessary actions to remove legal, managerial, financial, or skill barriers, with the contribution of the target population, caregivers, and professionals planned for, supported, and resourced. There is a defined strategy to align staff incentives and motivation with the practice objectives. The practice should offer a model of efficient leadership and should create ownership among the target population and several interested parties considering multidisciplinary, multi-/inter-sectoral, partnerships and alliances, if appropriate. The practice should be supported by different information and communication technologies (e.g., medical records system, dedicated software supporting the implementation of screening, social media etc.), defining a policy to ensure acceptability of information technologies among users (professionals and target population) to enable their involvement in the process of change.

8. Interaction with Regular and Relevant Systems

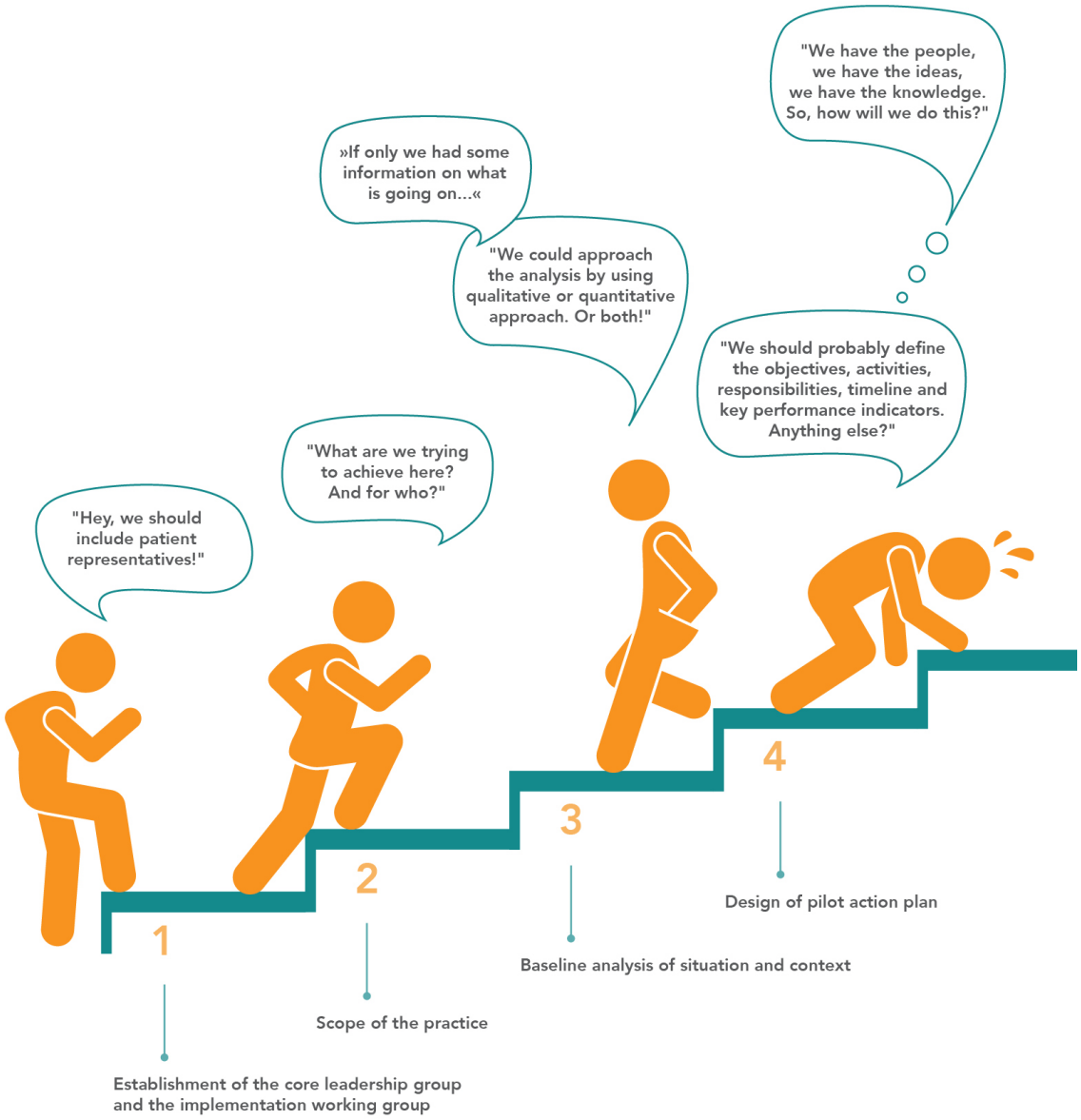
The practice should be integrated or interactive with regular healthcare and/or further relevant systems, enabling effective linkages between all relevant decision makers and interested parties, and enhancing and supporting the target populations' ability to effectively interact with the regular relevant systems.

9. Sustainability and Scalability

The continuation of the practice should be ensured through institutional commitment and/or ownership by the relevant interested parties or communities, as well as supported by those who implemented it. The sustainability strategy should consider a range of contextual factors (e.g., health and social policies, sex and gender issues, innovation, cultural trends, general economy, and epidemiological trends) that assesses the potential impact on the population targeted.

How to adopt & apply a good practice in seven steps

1. *Establishment of the core leadership group and the implementation working group*: involvement of interested parties with varying degree of participation – individuals, institutions or organisations that are in any way affected by the implemented practice, or are important for the sustainability/scalability of the practice. Target population participation is key!
2. *Scope of the practice*: problem, general purpose and target population are defined, and core elements of the practice are selected.
3. *Baseline analysis (Starting point) of situation and context*: identification of contextual factors that might affect the implementation using quantitative, qualitative or mixed methodology.
4. *Design of pilot action plan*: specific objectives, activities, responsibilities, timeline and key performance indicators are defined.



5. Monitoring and evaluation of the implementation: using PDSA (Plan-Do-Study-Act) approach, the outcomes of the evaluation are linked to actions to encourage continuous learning and/or improvement and/or to further reshape the practice.

6. Reporting of the results: reporting conveys core information and messages the scientific, professional, and lay communities as well as to the decision-makers and is an essential building element for the sustainability and scalability.

7. Planning for sustainability of the practice and to increase the potential for scale-up: sustainability of the practice can be ensured through institutional commitment and/or ownership/broad support by the relevant interested parties or communities. Sustainability is to be planned from day one of the implementation journey.

This summary document is the layman, non-expert, nonprofessional version of the **Guide for the implementation of JA CHRODIS Recommendations and Criteria** (in short: The Guide), that has been developed in Joint Action **CHRODIS PLUS**, a three-year initiative (2017-2020) funded by the European Commission (EC) and participating organisations with **42 partners** representing **20** European countries. The purpose of CHRODIS PLUS was to tackle the increasing burden of chronic diseases by promoting the acceptance and application of good policies and practices in this field. The full and short versions of the Guide can be found here.